Bethesda health care

PATIENT ADMISSION DETAILS

TO BE COMPLETED BY THE PATIENT OR SUPPORT PERSON.

Person completing this form: ..... ADMISSION TYPE: ☐ LA DAY CASE ☐ DAY CASE ☐ OVERNIGHT

Surgeon Name: ..... Admission Date: ..... Admission Time: .....

Operation/Procedure: .....

CMBS Item Number: .....

GP Name: ..... GP Practice Name: ..... Phone: .....

PERSONAL DETAILS

Have you been a patient at Bethesda before? ☐ Yes ☐ No If yes, previous name (if applicable) .....

Have you been a patient in any hospital in the past 28 days? ☐ Yes ☐ No If yes, the hospital was: .....

Title: ..... Patient Surname: ..... Given Name(s): .....

Preferred Name: ..... Date of Birth: ..... Age: ..... Gender: .....

Address (Residential): ..... Suburb: ..... Post Code: .....

Address (Postal): Same as Residential: ☐ Yes ☐ No ..... Suburb: ..... Post Code: .....

Phone: Home: ..... Work: ..... Mobile: .....

Email: ..... Preferred Contact: .....

Marital Status: ☐ Married/Defacto ☐ Never Married ☐ Separated ☐ Widow/Widower ☐ Divorced

Employment Status: ☐ Employed ☐ Unemployed ☐ Home Duties ☐ Retired ☐ Pensioner ☐ Student

Country/State of Birth: ..... Ethnicity: ..... Religion: .....

Language Spoken at Home: ..... Interpreter Services Required? ☐ Yes ☐ No

NEXT OF KIN

Relationship to Patient: .....

Full Name: .....

Same address as Patient? ☐ Yes ☐ No, if no complete below

Address: .....

After Hours: ..... Mobile: .....

Business Hours: .....

PERSON TO CONTACT IN AN EMERGENCY

Next of Kin ☐ Yes ☐ No. If not Next of Kin complete below

Full Name: .....

Same address as Patient? ☐ Yes ☐ No, if no complete below

Address: .....

After Hours: ..... Mobile: .....

Business Hours: .....

OVERNIGHT PATIENT'S ROOM PREFERENCE

☐ Private Room ☐ Shared Room

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

Patient ☐ Yes ☐ No. If not Patient, Title: ..... Full Name: .....

Address: ..... Phone: .....

PAYMENT DETAILS

Medicare No: ..... Patient Position on Card: ..... Expiry Date: .....

Health Fund Name: ..... Membership Number: ..... Tier: .....

Do you have an excess? ☐ Yes ☐ No If Yes, $ ..... Have you changed your fund/level of cover in the past 12 Months? ☐ Yes ☐ No

Pharmaceutical/Pension Entitlement Number: .....

DVA: File Number: ..... Card Colour: .....

Defence Force (ADF): Service No: ..... Base: .....

Insurer: ☐ WC ☐ MVA Date of Accident: ..... Insurance Company: .....

Claim No: ..... Employer: ..... Employer Address: .....

Case Manager: ..... Phone: .....

Procedure approval is required prior to admission. If not received, you may choose to use your private health insurance or to self-fund.

DO NOT WRITE IN THIS BINDING MARGIN

PATIENT ADMISSION DETAILS MR 4A

Rev: November 2024

Bethesda health care

PATIENT ADMISSION GENERAL HEALTH HISTORY

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

Please use I.D. or block print

Do you have an Enduring Power of Attorney/Substitute Decision Maker? ☐ Yes Name: ..... Phone: ..... ☐ No

Do you have an Advanced Health Directive? ☐ Yes (please bring a copy to the hospital with you) ☐ No

Nursing Use Only
Complete MRO Form

MEDICATION Please include all medications (patches, ointments, tablets etc.) that you use including over the counter and alternate therapies.
Please bring your medication to hospital in its original labeled packaging. We are unable to accept Dosette boxes.

Medication	Frequency	Dose	Medication	Frequency	Dose

Nursing Use Only
Patient own stock?
☐ Pt med drawer
☐ Schedule 8 + S4R secured
☐ Sent home

PRE-PROCEDURE MEDICATION MANAGEMENT	NO	YES	If YES, please complete below:	Nursing Use Only
Have you received advice from your doctor regarding taking/ceasing any medications prior to admission?	☐	☐	Medication to be ceased: ..... Date to be ceased or last taken:	
Do you take any anti-coagulant or blood thinning medication? eg: Warfarin, Coumadin, Plavix, Iscover, Aspirin, Apixaben, Dabigatran, Rivaroxaban, Prasugrel & Ticagrelor	☐	☐	If yes has your doctor advised you to cease this medication prior to your surgery? ☐ Yes ☐ No Which medication: ..... Date to be ceased or last taken:	

PROCEDURE/ADMISSION	NO	YES	If YES, please complete below:		Nursing Use Only
Are you or could you be pregnant?	☐	☐	Date of last menstrual period:		
Have you had any tests or x-rays taken for this admission?	☐	☐			
Blood Test	☐	☐	When:	Where:	
MRI, Xray, Scan, Ultrasound	☐	☐	☐ With me	☐ With my doctor	
Have you consulted with a cardiologist or physician recently?	☐	☐			
Cardiologist	☐	☐	Dr Name:		
Physician	☐	☐	Dr Name:		

PREVIOUS SURGERY/PROCEDURES	NO	YES	If YES, please complete table below:
Have you had any previous surgeries or procedures?	☐	☐	

Operation	Approx. Year	Operation	Approx. Year	Nursing Use Only

DO NOT WRITE IN THIS BINDING MARGIN

MR 4B

Bethesda health care

PATIENT ADMISSION GENERAL HEALTH HISTORY

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

Please use I.D. or block print

DO NOT WRITE IN THIS BINDING MARGIN

ALLERGIES AND POST OPERATIVE COMPLICATIONS

Allergies or adverse reactions complete section below, if yes please provide details and dates	NO	YES	**Please complete below:**		Nursing Use Only
Do you have any allergies or sensitivities? e.g. medications, latex, sticking plaster, iodine, x-ray dyes, food (seafood, nuts, fruit, eggs, gluten, food additives such as salicylates, amines) insects such as bees and dust mites	☐	☐	Allergy substance:	Reaction:	Alert sticker ePAS entry
Have you or a family member:			You	Family Member	
Reacted to anaesthetic?	☐	☐	☐	☐	
Had/been tested for malignant hyperthermia?	☐	☐	☐	☐	
Had post operative nausea or vomiting?	☐	☐	☐	☐	
Had difficulties urinating after surgery?	☐	☐	☐	☐	

LIFESTYLE	NO	YES	**Please complete below:**		Nursing Use Only
Do you have a medically required or a preferred diet? e.g. diabetic, coeliac, vegan, vegetarian, lactose intolerant, kosher	☐	☐			
Have you ever smoked?	☐	☐	Daily amt:	Ceased:	
Do you drink alcohol?	☐	☐	How many days per week? ..... How many standard drinks per day?		
Do you use recreational drugs?	☐	☐			
What is your weight? kg			**For your safety, we are unable to admit patients who weigh >150kg and/or have a BMI >45. Please call the hospital on (08) 9340 6300**		Check BMI <18 >40
What is your height? cm					
Have you lost >5kg in weight unintentionally?	☐	☐			MST Plan

PROSTHETICS/AIDS/ FALLS RISK ☐ Yes, complete details below ☐ No, go to next section	NO	YES	**Please complete below:**	Nursing Use Only
Do you have any hearing or vision deficits and do you use any aids/prosthetics? e.g., aids for vision, hearing, walking, other aids for daily living	☐	☐		If yes to either, complete FRAMP
Have you had a fall in the last 12 months or do you fear falling or feel unsteady on your feet?	☐	☐		

MEDICAL CONDITIONS			**Please complete below:**	Nursing Use Only
Cardiovascular Have you ever had any problems with your heart or circulation? ☐ Yes, complete details below ☐ No, go to next section				
	NO	YES		
High cholesterol, triglycerides	☐	☐		
Blood pressure problems (low or high), requiring treatment or medication	☐	☐		
Cardiac conditions eg: heart attack, congestive heart failure, rheumatic fever, valve disease, chest pain, angina	☐	☐		
Cardiac irregularities eg: palpitations, irregular heartbeat, heart murmur, atrial fibrillation	☐	☐		
Cardiac surgery eg: pacemaker, implants or devices, prosthetic heart valve, grafts, stents	☐	☐	Year: ..... Model:	
Vascular disease eg: carotid disease, aortic aneurysm, peripheral vascular disease	☐	☐		
Other:	☐	☐		

Skin Integrity Do you have any of the following? ☐ Yes, complete details below ☐ No, go to next section	NO	YES	**Please describe below:**	Nursing Use Only
Skin Tear	☐	☐		
Wound	☐	☐		
Pressure Injury	☐	☐		☐ Pressure Assessment Management Plan
Skin Conditions e.g. psoriasis, eczema	☐	☐		

MR 4C

Bethesda health care

PATIENT ADMISSION GENERAL HEALTH HISTORY

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

Please use I.D. or block print

Diabetes

Do you have or have you previously had diabetes? ☐ Yes, complete details below ☐ No, go to next section

	NO	YES
Type 1 diabetes	☐	☐
Type 2 diabetes	☐	☐
Gestational diabetes	☐	☐

Please describe below:

Controlled by:

☐ Diet ☐ Insulin

☐ Tablets ☐ Pump

Nursing Use Only

Gastroenterology /Urology

Have you ever had any problems with your stomach, bladder or bowel? ☐ Yes, complete details below ☐ No, go to next section

	NO	YES	Please describe below:	Nursing Use Only
Hiatus hernia, gastrointestinal ulcers, reflux	☐	☐		
Liver disease, hepatitis (eg: A, B, C), jaundice, cirrhosis	☐	☐		
Bowel problems/habits, stoma or bowel disease eg: Crohns, IBS	☐	☐		
Kidney disease, dialysis, renal impairment	☐	☐		
Bladder problems/habits, stoma, incontinence, urinary retention	☐	☐		☐ FRAMP
Other:	☐	☐		

Blood

Have you ever had a blood transfusion or blood condition? ☐ Yes, complete details below ☐ No, go to next section

	NO	YES	Please describe below:	Nursing Use Only
Blood transfusions	☐	☐	Year transfused: ..... Any reaction:	
Blood clots in lung or leg (PE/DVT)	☐	☐		☐ VTE Plan
Blood or bleeding disorders e.g. anaemia	☐	☐		
Other:	☐	☐		

Cancer	NO	YES	If YES, Please describe below:	Nursing Use Only
Do you have a history of cancer?	☐	☐	Type: ..... Body site: ..... Treatment: ..... Date of diagnosis:	☐ VTE Plan

Musculoskeletal

Have you ever had any musculoskeletal conditions? ☐ Yes, complete details below ☐ No, go to next section

	NO	YES	Please describe below:	Nursing Use Only
Arthritis eg: rheumatoid or osteoarthritis	☐	☐		
Back or neck injury/ problems	☐	☐		
Joint Replacement	☐	☐		

Neurological

Have you ever had any neurological conditions? ☐ Yes, complete details below ☐ No, go to next section

	NO	YES	Please describe below:	Nursing Use Only
Neuromuscular disease eg: MS, MND, Parkinsons	☐	☐		☐ FRAMP
Stroke, mini-stroke, TIA	☐	☐	Date: ..... Impairment:	☐ FRAMP
Limb paralysis or weakness	☐	☐		☐ FRAMP
Epilepsy/ fits, faints, blackouts, dizziness	☐	☐		☐ FRAMP
Difficulties with problem solving, attention span, understanding, confusion post surgery, short term memory loss, dementia, Alzheimer's	☐	☐		☐ 4AT
Other neurological problems eg: migraine, meningitis, polio	☐	☐		

DO NOT WRITE IN THIS BINDING MARGIN

Bethesda health care

PATIENT ADMISSION GENERAL HEALTH HISTORY

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

Please use I.D. or block print

DO NOT WRITE IN THIS BINDING MARGIN

Breathing Have you ever had any problems with your breathing or lungs? ☐ Yes, complete details below ☐ No, go to next section	NO	YES	**Please describe below:**	Nursing Use Only
Asthma, pneumonia, hayfever, asbestosis, bronchitis, emphysema, Chronic Obstructive Pulmonary disease (COPD), home oxygen	☐	☐		
Shortness of breath eg: walking more than 50m, climbing stairs or inclines	☐	☐		
Sleep apnoea, disturbed sleep, snoring	☐	☐		Stop Bang Score:
Use of a CPAP machine	☐	☐	Please bring CPAP to hospital	
Other lung problems eg: tuberculosis	☐	☐		

Mental Health	NO	YES	**Please describe below:**	Nursing Use Only
Do you have a mental health condition such as depression, anxiety, bipolar or PTSD?	☐	☐		

Other Conditions Please complete section below, if yes please provide details and dates	NO	YES	**Please describe below:**	Nursing Use Only
Chronic pain	☐	☐		
Lymphoedema	☐	☐	Limb:	
Thyroid problems, hypothyroidism, goitre	☐	☐		
Any other medical conditions	☐	☐		

INFECTION RISK Please complete section below, if yes please provide details and dates	NO	YES	**Please describe below:**	Nursing Use Only
Have you had an antibiotic resistant infection? Such as MRSA, VRE, CRE, ESBL or C *Auris*	☐	☐		
In the last 12 months have you been admitted overnight, worked or volunteered in a hospital or residential care facility outside WA?	☐	☐	Where:	
Are you a resident of a residential care facility or have you been admitted overnight to a hospital in WA In the last 12 months?	☐	☐	Name of facility/hospital:	
Do you have respiratory symptoms?	☐	☐		
Do you have a history of travel outside of WA within the last 14 days?	☐	☐	Countries visited:	
Do you have two or more first or second-degree relatives with Creutzfeldt-Jakob disease (CJD)?	☐	☐		
Do you have an unexplained progressive neurological illness of less than 12 months duration?	☐	☐		
Do you have a history of receiving human pituitary hormone for infertility or human growth hormone for short stature (prior to 1986)?	☐	☐		
Have you previously had surgery on the brain or spinal cord that included a dura mater graft (prior to 1990)?	☐	☐		
Have you been involved in a 'look-back' for CJD or do you have a 'medical in confidence' letter regarding your risk for CJD?	☐	☐		

Please notify your doctor and the hospital if you become unwell with a cold, respiratory symptoms, diarrhoea or vomiting in the week prior to your admission.

DISCHARGE PLANNING Where do you plan to go after discharge? **(Please note you will be unable to drive or take public transport or a taxi alone and will need a responsible carer to escort you home and remain with you for 24 hours after your anaesthetic/sedation if a day patient)**	NO	YES		Nursing Use Only
Do you have someone to look after you after discharge?	☐	☐	Name:	
Do you live alone?	☐	☐		
Are you solely responsible for the care of another person at home?	☐	☐	Details:	
Do you **currently** require assistance with daily activities?	☐	☐	Details:	
Do you have concerns about how you will manage after discharge?	☐	☐		
Would you like to discuss your admission or discharge needs before your admission?	☐	☐		
Is there any other information that you think would help us while you are in hospital?	☐	☐		

Bethesda health care

PATIENT HEALTH HISTORY
Additional Clinical Information

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

Please use I.D. or block print

ADDITIONAL CURRENT MEDICATIONS

Medication	Dose	Frequency

ADDITIONAL SURGICAL HISTORY / OPERATIONS

Operation	Date Performed

ADDITIONAL ALLERGIES

Allergies	Reaction

Nursing Staff

Document on Anaesthetic and Medical Record - Alert sheet and NIMC.

If latex allergy, follow latex policy.

ADDITIONAL NOTES

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MR 4F

Bethesda health care

STAFF USE ONLY

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

Please use I.D. or block print

NURSE USE ONLY

RISK PLANNING REQUIRED	Required	Not Applicable	Date Completed	Signature
Falls Risk Screen	Yes			
• Falls Risk Assessment Management Plan (FRAMP)				
Infection Risk Screen	Yes			
• Infection Risk Plan				
Pressure Injury Screen	Yes			
• Pressure Assesment Management Plan				
Cognitive Impairment Screen (aged 65 years of age and over)				
• 4AT Plan				
VTE Risk Screen	Yes			
• VTE Plan				
STOPBang Screen	Yes			
• Obstructive Sleep Apnoea (OSA) Risk Interventions				
Malnutrition Risk Screen				
• Malnutrition Plan				

HISTORY RELEVANT TO ADMISSION (include any accident details such as fall, work or sports injury):	NAME, SIGNATURE & DESIGNATION

PREADMISSION NOTES

DATE/TIME		

CONFIRMATION - Patient history form has been reviewed

ADMISSION CLERK	Name: ..... Initials: ..... Signature:	Date: ..... Time: .....
PRE-ADMISSION NURSE	Name: ..... Initials: ..... Designation: ..... Signature:	Date: ..... Time: .....
ADMITTING NURSE	Name: ..... Initials: ..... Designation: ..... Signature:	Date: ..... Time: .....
WARD NURSE	Name: ..... Initials: ..... Designation: ..... Signature:	Date: ..... Time: .....

DO NOT WRITE IN THIS BINDING MARGIN

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Bethesda health care

CONSENT TO USE AND DISCLOSE PERSONAL INFORMATION

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

Please use I.D. or block print

DO NOT WRITE IN THIS BINDING MARGIN

PATIENT OR PERSON RESPONSIBLE FOR PATIENT TO READ AND SIGN

Bethesda Health Care is committed to managing your personal health information according to the current Australian Privacy Act. More information is available on our website www.bethesda.org.au or by contacting our Privacy Officer on (08) 9340 6300

Consumer Approved

COLLECTION

Bethesda Health Care staff will collect your personal information:

- that is necessary for your safety, optimal care and treatment;
- that is required by law;
- that is necessary for billing and the business management of our service; and
- that enables us to monitor our service quality and customer satisfaction.

We may also need to obtain and share information from other sources such as your GP, other healthcare providers and hospitals, including pathology laboratories and the My Health Portal System. In emergency situations we may need to collect personal information from your next of kin, your relatives or other sources.

USE AND DISCLOSURE

Your information will be used as listed above and also:

- to inform manufacturers of any prosthetic or medical devices you may receive as part of your treatment, for safety and regulatory purposes. These manufacturers may be located overseas;
- to inform the person you have nominated of your health status;
- for account keeping and billing, including sharing information with health insurer's, Medicare and, if required, outside collection agencies;
- for the management of patient safety, training and education, quality assurance and accreditation purposes; and
- where legally required, such as producing records to court and mandatory reporting of information to State and Federal authorities, including the notification of certain communicable diseases.

ACCESS TO YOUR MEDICAL RECORD

You are entitled to access your own medical record at any time convenient to both yourself and the hospital. Requests or queries must be directed to our Privacy Officer. The request will be actioned within 30 days of receipt and a charge for photocopying, staff time and processing your request may be made.

Access may be denied where:

- there is a legal impediment to access;
- the access would unreasonably impact on the privacy of another person;
- your request is frivolous;
- the information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings;
- it is in the interests of National Security; or
- it would create a serious threat to life or health if access was granted.

SECURITY AND CONFIDENTIALITY OF YOUR INFORMATION

We have policies, processes and storage systems that comply with relevant legislation to ensure your information is protected from misuse, interference, loss, unauthorised access, modification or disclosure. Information will be retained for the period of time determined by current Australian legislation and will be disposed of confidentially in line with legislated document disposal schedules.

MAKING AMENDMENTS TO YOUR MEDICAL RECORD

You are entitled to amend the information on your medical record. We will take steps to record, all of your amendments, and place them with your medical record but will not erase the original record. Please contact our Privacy Officer.

WITHHOLDING SENSITIVE INFORMATION

You may request certain information be withheld for personal reasons. Bethesda may not be able to admit or treat you where it considers the information is not comprehensive enough to provide quality health care.

USE OF A PSEUDONYM

You may choose to be known by a pseudonym (alias) while in hospital, however your accurate identifying details may be required for our billing purposes but will be kept confidential.

WITHDRAWING CONSENT

If you provide your consent to release information to other parties or for other purposes and would like to withdraw this consent, please contact our Privacy Officer

FEEDBACK AND COMPLAINTS PROCESS

Please lodge any feedback via our Patient Feedback Surveys, via our website www.bethesda.org.au or contact our Privacy Officer.

CONSENT:

Bethesda Health Care is an independent private hospital that has been providing outstanding medical and health services to the WA community for close to 80 years.

We would like to update you on our latest activities and keep you informed about new services, fundraising campaigns and Volunteer activities. To do this we would need to utilise your personal information provided to us. To comply with privacy laws we are asking your permission to do so. If you would like to opt out of receiving updates about Bethesda Health Care, please tick here: ☐

I consent to Bethesda Health Care managing my personal information as detailed above.

Do NOT upload medical documentation from this admission to My Health Record: ☐

Patient's name: .....

Signature: .....

If consenting on behalf of the patient as a person responsible / other please print and sign:

Guardian's name: .....

Signature: .....

Relationship to patient: .....

Date: ...../...../ 20.....

MR 4H

Bethesda health care

CONSENT TO PROCEDURE

Surname:	MRN:
Given Names:	
DOB:	Gender:
Address:	

Please use I.D. or block print

ADMITTING DOCTOR: **ADMISSION TYPE** ☐ **LA DAY CASE** ☐ **DAY CASE** ☐ **OVERNIGHT**

ADMISSION DATE: **TIME:** **ITEM NUMBERS:**

PROVISIONAL DIAGNOSIS:

ADMISSION CRITERIA **HEIGHT:** **WEIGHT:** **BMI:**

For safety reasons patients whose weight exceeds 150 kgs and/or BMI >45 will not be admitted to Bethesda

I, _____ (full name of person giving consent)

of _____ (address)

hereby consent to the following procedure (s) _____

_____

_____(no abbreviations, please print)

being performed upon _____(full name of patient if different from self)

the nature and effect of which has been explained to me by Doctor_____

I also consent to:

- further procedure(s) as may be found necessary to be performed during the course of the procedure(s), stated above and to the required post-operative treatment;
- digital images being made during my procedure and, if made, copies being retained as part of my medical record;
- the administration of such anaesthetics and medicines as may be considered by the anaesthetist to be necessary or advisable;

- **to the transfusion of blood products if needed ☐ Yes ☐ No (please tick). The risks have been explained to me. (if no, a Refusal of Blood Product form must be completed);**

- blood being collected and tested for infectious agents (including Hepatitis and HIV antibody) in the event of an occupational exposure to a staff member. I understand I will be informed that blood has been taken for testing, that there will be no additional cost to myself and the results of the test will be made available to me, the staff member and the infection control officer of the hospital. **All health care workers are bound to maintain confidentiality of the test results.**

Patient/Guardian signature _____Relationship to patient _____ Date____/ ____/20____
(if not self)

I (Doctor's name) _____ confirm that I have explained to the patient (or person legally responsible for the patient) the nature, purpose, benefits and risks of the proposed procedure(s) and in my opinion he/she understands my explanation.

Medical practitioner's signature: ..... Date____/ ____/20____

Interpreter's declaration: Specific language requirements (if any). I declare that I have interpreted the dialogue between the patients and health professional to the best of my ability, and have advised the health professional of any concerns about my performance.

Interpreter's full name: _____ **Date** ___/___**/20**____ **Time** _____

Agency name: _____ **Interpreter's signature:** _____

MEDICAL USE ONLY
CRUETZFELDT-JAKOB DISEASE RISK

Will the intended procedure involve dura mater, cranial or dorsal root ganglia, spinal cord or olfactory epithelium?

Do you think the patient may have CJD? ☐ NO ☐ YES
If yes please contact Bethesda Infection Control Manager.

Medical Practitioner's Signature: .....

MEDICAL PRACTITIONER
PREOPERATIVE INSTRUCTIONS

_____

_____

_____

_____

Medical Practitioner's Signature: .....

DO NOT WRITE IN THIS BINDING MARGIN

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25 Queenslea Drive, Claremont WA 6010
admissions@bethesda.org.au
www.bethesda.org.au